

## JRI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-60-042712

FILED VS. DEC 12 1960

STATE FILE NUMBER

Registration District No. 184 Primary Registration District No. 3038 Registrar's No. 145

1. PLACE OF DEATH a. COUNTY <b>Linn</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY <b>Chariton</b>			
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Brookfield</b>		Length of stay in 1b <b>3 mos.</b>		c. CITY OR TOWN <b>Summer</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF HOSPITAL OR INSTITUTION <b>Brookfield Nursing Home</b>			Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location)		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>CHARLES D. WRIGHT</b>				4. DATE OF DEATH Month <b>December</b> Day <b>3</b> Year <b>1960</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>9-11-1875</b>	9. AGE (last birthday) <b>85</b>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Grain dealer, ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Grain</b>		11. BIRTHPLACE (City and state or country) <b>Linneus, Missouri</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>	
13a. FATHER'S NAME <b>James F. Wright</b>		13b. MOTHER'S MAIDEN NAME <b>Eliza Lowe</b>		14. NAME OF HUSBAND OR WIFE <b>Maud C. Callaway Wright</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Harold B. Wright, Brookfield, Mo.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Venturated I. bacteria</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 hours</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Acute coronary atherosclerosis</u> DUE TO (c) <u>Generalized arteriosclerosis</u>						<u>6 hours</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Cocaine, Semerity</u>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year							
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION		COUNTY		STATE	
21. I attended the deceased from <u>Oct. 12, 1955</u> to <u>Dec. 3, 1960</u> and last saw her alive on <u>Dec. 3, 1960</u> . Death occurred at <u>1:00 p</u> m on the date stated above, and to the best of my knowledge, from the causes stated.							
22a. SIGNATURE <u>J. W. Bohman M.D.</u>		(Degree or title)		22b. ADDRESS <u>347 D. Main Brookfield Mo</u>		22c. DATE SIGNED <u>12/3/60</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>Dec. 5, 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lakeside Cemetery</b>		23d. LOCATION (City, town, or county) <b>Summer, Mo.</b>			
24. FUNERAL DIRECTOR <b>Wright Funeral Home, Brookfield, Mo.</b>		ADDRESS		25. DATE RECD. BY LOCAL REG. <b>12-5-60</b>		26. REGISTRAR'S SIGNATURE <u>Katharine Johnson</u>	

(Licensed Embalmer's Statement on Reverse Side)

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed W. B. Wright

Licensed Embalmer No. 4655

P. O. Address Meadville, Pa.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to conform with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.